COMMENTS
For the STATE of ILLINOIS
Office of the Governor
Health Care Reform Implementation Council

Many people. Many options.
Bring them together.

ACS, a Xerox Company, is pleased to respond to the opportunity and invitation to provide the State of Illinois' Office of the Governor's Council of Health Care Reform Implementation Council with our input on Health Insurance Reform and the Option of Establishing an Insurance Exchange in Illinois. We respect and embrace the State's forward thinking approach for the inclusionary invitation to comment on the State's option to establish an "American Health Benefits Exchange ("Exchange") in the State of Illinois. While ACS Government Healthcare does not have a large footprint in the State of Illinois; we do have over 700 employees living and working in the state. Currently we operate the State Distribution Unit for child support payments on behalf of the Department of Healthcare & Family Services. In addition, Buck Consulting; an ACS company, maintains an office in Chicago with over 100 employees. We also perform a number of services for our commercial clients in the greater Chicago area. Our Healthcare Recovery Services business is based in IL as well. We would like to take this opportunity to comment and share our understanding of the key issues you will face as a state in establishing an Exchange that is fitting for the Illinois marketplace; provide you with specific responses to some of the questions you ask consideration of; and, introduce you to the ACS experience, innovation and results driven company that we are. ACS bid high scoring solutions to the HHS National Insurance Exchange Portal and the Florida Invitation to Negotiate for HealthChoices – a small business health insurance marketplace. We would welcome the opportunity to bring the same caliber of due diligence and quality to the Illinois Exchange solution.

To achieve the promise of the national health care reform law, the federal government has established and continues to design the Exchange framework and minimum requirements under which many provisions of the law are implemented. Within this framework, though, vested Illinoisans will make many key decisions and serve as critical partners in the implementation process. The legislation provides every Illinoisan access to health insurance information which will present a great challenge to your state resources. This invitation to comment is a testament to your understanding of the many key decisions that you must consider, and the options to contemplate to ensure the ultimate success of the Illinois Health Benefit Exchange.

I. Functions of a Health Benefit Exchange

Passed in March, 2010, the Patient Protection and Affordable Care Act (ACA) contains several new healthcare reforms. Among them is a requirement for state-built and administered healthcare Exchanges to operate in each state by 2014. The Exchanges, which are expected to cover as many as 24 million people by 2019, will function as insurance markets and allow individuals and small businesses to purchase insurance from qualified health plans within the Exchange. By law, HHS must establish minimum requirements for the Exchanges; but each state can determine the governing rules, powers, and scope of the entities. States have the option of operating separate Exchanges for individuals and businesses or combining the Exchanges into a single entity that encompasses both groups.

They also have several options regarding administration. A state may establish Exchanges for its different geographic areas, or it may join with other states to form a regional Exchange. States can also allow the federal government to operate their Exchanges. Presumably, all states would take advantage of adopting the optional functions to the greatest extent feasible; provided the state can afford to do so. Choosing to take advantage of the optional functions requires an assessment of resources to dedicate to them; while ensuring that the mandatory functions are fulfilled.

(?) What, if any, Exchange functions beyond the minimum clearinghouse functions required in the ACA would benefit Illinois and why?
Beyond the minimum functions the State can do the following:

- Establish a portal that is a TRUE single source of truth for education, selection and client support.
- Establish an electronic and operational link to the Medicaid Program.
- Create a Customer Service Operation and Call Center to respond to customer needs including consumer questions.
- Develop a healthcare eligibility subsidy workflow process to determine who is eligible for subsidies and who is exempt from penalties imposed for going without insurance.
- Design a computer system to exchange data with state Medicaid agencies, insurance agencies, employers and federal agencies.

II. Structure and Governance

The reform law stipulates that the Exchanges will be run by either the state government or by a state-recognized non-profit entity. The expectation is that almost all Exchanges will be administered by a state agency — either one now existing or one formed exclusively for the purpose of running the Exchange. With so many entities working together, it's important to know and include all existing and prospective Stakeholders of the Illinois Exchange in contemplating the structure and governance of operating it.

(?) If the Illinois chooses to establish its own Exchange, which governance structure would best accomplish the goal of more affordable, accessible health insurance coverage? Why?
ACS believes that the Illinois Exchange is best served in a quasi-governmental entity that links with other state agencies, perhaps other states on a regional basis, and the Federal government to leverage all governmental resources.

(?) If the Exchange is run by an executive director and/or a governing board, what should be the expertise of those appointed? How long should the terms be? Are there existing models to which the State should look?
The two established models are Massachusetts and Utah, two very diametrically different models. The model chosen should be a blend of governmental and private health insurance.

Insurance Agency
Insurance Commissioners will certainly play an integral role in shaping the management of their individual state's Exchange. As they are responsible for licensing companies to do business in the state, they will insist on evaluating and approving any insurance company seeking to participate in the Exchanges.

Medicaid and CHIP Agencies
These two agencies (often the same) have specific obligations to the Exchanges that are outlined in the enacted reform law, including:

• By 2015, states must report all changes in Medicaid enrollment to CMS. A substantial portion of that enrollment may come through Exchanges.

• Medicaid must enroll all people that the state Exchanges identify as eligible.

• Medicaid, CHIP and the Exchange must use a secure electronic interface capable of determining individual's eligibility for coverage.

• When Medicaid/CHIP finds people ineligible for those programs, provisions must be made to refer them to the Exchange to be reviewed for coverage and possible state-specific subsidy eligibility. Because of these obligations, these agencies are heavily involved in how the Exchanges are forming in each state.

Newly Created Agencies
While new agencies could be created to run the Exchange, Medicaid programs and the insurance regulators are certain to be involved. The Illinois Exchange could either function as an existing Illinois government agency or department, subject to compliance with civil service rules, public contracting, open

records/meeting laws, etc. Alternatively, it could be created as an independent, non-profit public entity. Models developed by other states offer some examples for consideration.

> The Massachusetts Health Insurance Connector Authority is an independent state authority not answerable to any other executive department or board, governed by a 10-member board composed of four designated public officers, three members appointed by the governor, and three appointed by the attorney general.
>
> The Utah Health Exchange is operated by the Office of Consumer Health Services, which is part of the Governor's Office of Economic Development.
>
> The Florida Choices Board, though not yet designated as the official exchange entity, is a cross functional group enabled by the legislature pre health reform, and constituted by a cross functional mix of advocates, and government representatives
>
> The proposed California Health Benefits Exchange is also an independent agency governed by a five member board, including one appointee of the California Secretary of Health and Human Services, two members appointed by the Governor, one by the Senate Committee on Rules, and one by the Speaker of the Assembly.

Some Exchange functions could be handled readily by a private entity. These include operating a Web portal and processing enrollments or premium payments. As noted above, such functions can be outsourced to private entities under the ACA. Other functions, however, such as certifying that making a health plan available "is in the interests of qualified individuals and qualified employers," or taking unreasonable premium increases "into account" in determining whether to offer a health plan, are arguably "inherently governmental." Exchanges may also exercise governmental discretion in determining eligibility for premium subsidies or Medicaid.

Make or Buy?

Retaining the Exchange as a public function may be a more efficient use of public resources. The question of whether to establish an Exchange as a government agency or as an independently contracted organization is analogous to the make-or-buy decisions common to private firms.

Agency or Board?

Many states will determine whether the Exchange will fit within an existing government agency, such as the Insurance Department. Although the Exchange

must coordinate closely with the Insurance Department, it is quite possible that not all insurance plans will be certified for participation in the Exchange, and selecting among plans would be inconsistent with the impartiality that must be shown by an Insurance Commissioner. Moreover, the fundamental role of an Exchange is to market insurance products, while the basic role of an insurance commissioner is to regulate insurance and protect consumers. It may or may not make sense to house the Exchange within the Illinois Medicaid agency, since many participants will not be on Medicaid and will have different needs from those of Medicaid recipients. It might make sense to house the Exchange within a broader consumer protection agency, depending on the nature of that agency within Illinois. Illinois may also want to follow Utah's example and house the Exchange in the governor's office, where it might have more status and access to power and be less subject to the politics and bureaucracy of an existing agency.

III. External Market and Addressing Adverse Selection

To the extent possible, Illinois regulation of the individual and small-group market should be identical outside and within the Exchange. Some states may be able to eliminate the market outside the Exchange. To discourage adverse selection both against and within the Exchange, HHS might design a sophisticated, but practical risk-adjustment system allowing Illinois to adjust risk among participating and nonparticipating insurers.

The greatest threat facing Exchanges is adverse selection. As long as individual or small-group coverage is readily available outside the Exchange, the potential exists for healthy individuals and groups to purchase insurance proportionately outside the Exchange. If an Exchange becomes essentially a high-risk pool, the Exchange will become unattractive to insurers while coverage through the Exchange will become unaffordable to individuals and to employers.

The ACA permits both an individual and a group health insurance market to continue to exist outside the Exchange, leaving open the possibility of adverse selection against the Exchange if lower-risk subscribers can find less-expensive coverage elsewhere. In addition, the ACA permits grandfathering of plans outside the Exchange. Many of the requirements of the ACA do not apply to individual and group health plans that existed on the date the ACA was adopted. Fortunately, a number of ACA provisions will discourage adverse selection. Because a market will continue to exist outside the Exchange, however, the ACA does not eliminate the possibility of adverse selection. Only "qualified" health plans can be sold within the Exchange. Qualified health plans must comply with all of the requirements in the ACA that apply to health plans generally, but must also comply with additional requirements that might make them more expensive than plans outside the Exchange, in turn making the non-Exchange plans more attractive to healthier individuals who might prefer less-expensive to more-protective plans.

The additional requirements may also make marketing plans through the Exchange less attractive to insurers. Health insurers within the Exchange must offer gold- and silver-level coverage as a prerequisite to selling other levels of coverage. However, they do not need to participate in the Exchange if they choose not to, and can remain outside the Exchange marketing "bronze"-level high cost–sharing plans, or catastrophic plans, which can be sold to people under 30 or to persons who cannot find affordable policies. This leaves open the possibility for healthy individuals or small employers to purchase minimum coverage outside the Exchange, threatening significant adverse selection against it. Self-insured plans are subject to even less-rigorous requirements under the ACA, and might offer coverage that is substantially less protective than Exchange coverage.

Although the ACA does not allow the Federal government to require individuals or employees to purchase insurance through the Exchange, it does not prohibit Illinois from imposing additional requirements on the outside market to discourage adverse selection. The ACA only preempts Illinois laws that would "prevent the application" of the ACA and Illinois laws prohibit or tightly regulating the sale of insurance outside the Exchange would not violate that principle. The only constraint on Illinois regulation of the health insurance market is that Illinois cannot, because of ERISA, directly regulate self-insured plans.

(?) What other mechanisms to mitigate "adverse selection" (*i.e.* requiring the same rules for plans sold inside and outside of the Exchange) should the state consider implementing as part of an Exchange?
Health plans must not be allowed to cherry pick consumers by excluding for pre-existing conditions or dropping coverage when they become ill. Individuals should not be allowed to forgo coverage when healthy and then demand it when sick. The Exchange model will work best for large pools of consumers which perhaps could include state employees.

IV. Structure of the Exchange Marketplace

ACS offers four fundamental suggestions for the structure of the Illinois Exchange Marketplace to be most effective:

- Establish consistent insurance market rules both inside and outside the exchange.
- Encourage (or require) insurers to offer identical both inside and outside the exchange;
- Merge individual and small-group markets over time; and
- Manage risk-adjustment and risk-pooling requirements to achieve effectiveness.

(?) Should Illinois permit large group employers with more than 100 employees to participate in the Exchange beginning in 2016? Are there any special considerations for including this group of which the State should be aware? Large employers who have invested heavily in employee health insurance programs may not respond well to pressure to conform and therefore the State may want to offer alternative solutions to ensure greater compliance.

V. Self-Sustaining Financing for the Exchange

Some provisions of ACA will take effect almost immediately, but will take time to have a major effect on state healthcare programs. Others will not go into effect at all for two or three years or more. Nevertheless it will be important for the State to consider and evaluate what initial steps should be taken to implement some of these measures. By beginning the planning process far in advance of the implementation dates prescribed in ACA, the State can ensure that it is making informed decisions and allowing a smooth and more efficient implementation of the new Federal law; including the financial sustainability by January of 2015. Illinois's implementation of the ACA could result in some significant increases in state health program costs. However, the new Federal law also establishes a number of new Federal grant programs—some monies distributed by formula, others awarded through a grant application process. Given the significant fiscal challenges ahead for the state, it will be important for the State to ensure that state agencies maximize their opportunity to obtain additional Federal funds, particularly in cases where doing so could offset state General Fund costs or assist the state with the transformation of Illinois's healthcare system under ACA.

The long–term implications of the new law for state health programs could increase state costs. Financing options should consider the state budgeting process, the methods by which the state collects and funds current public benefit programs, and whether such methods should be modified for the Exchange. Funding for certain hospitals will be affected. The state will face challenges in coordinating the new health benefits exchange with other state health programs and in changing eligibility processes to conform to new Federal requirements. Further changes will need to be considered in children's health coverage and high–risk pools, as well as the provision of coverage to those who remain uninsured. An analysis of the new Federal funding opportunities offered by the ACA for impact on the State of Illinois's Exchange financing may include:

- Medical Homes for Persons with Significant Health Needs
- Optional Attendant Services Benefit
- Bundled Payments for Hospitalization
- Incentives for Pediatric Accountable Care Organizations (ACOs)
- Additional Funding for Primary Care Clinics
- Prevention and Public Health Fund
- Maternal, Infant, and Early Childhood Home Visiting Program

Many of the major health reform provisions impacting Illinois will take effect in 2014. These include eligibility expansions, as well as changes in how the state determines program eligibility and payments for services. For some of these requirements, the government has provided enhanced funding to facilitate the Federal state's implementation. Nevertheless, these required changes will put significant fiscal pressure on the state in the out–years, particularly as the enhanced Federal funding is somewhat reduced. The exact cost to the state of these provisions cannot be determined with precision at this time because in a number of cases (1) Federal authorities have not issued Federal regulations and other types of guidance that could greatly affect the way they are implemented, and (2) the state has some leeway in how these Federal mandates are implemented. Nonetheless, our initial assessment is that the state eventually faces the risk of additional state costs.

Eligibility Determinations

The legislation provides everyone in the State of Illinois access to health insurance information — as well as a great challenge to your resources. In the next few years, every state must implement online portals for citizens to determine their eligibility for and comparison shop for health insurance at competitive prices and choose a carrier. Successfully implementing and managing a Health Insurance Exchange requires a combination experience in healthcare, technology and administration. Solutions should build on your population's health data to help match needs to the best-suited carriers while finding new financial services to pay for them. In our experience, data-driven eligibility for automatic enrollment is at the core of efficient participation levels in health care programs, while lowering administrative and operational costs. Success factors for eligibility determinations include:

- Replacing traditional application forms with data to establish eligibility;
- Integrated eligibility system coordinating multiple subsidy programs with a single application form; and
- Well designed outreach and education campaign to reach and engage all stakeholders.

(?) How should the Exchange's operations be financed, after federal financial support ends on December 31, 2014?

A blend of a public-private funding model needs to be developed. Insurers who are marketing their product through the Exchange should contribute and be charged a fee.

ACS Capabilities as an Effective Exchange Partner

Operating an Exchange involves handling massive amounts of information quickly, efficiently, and securely on behalf of millions of people. To be successful and sustainable, every state, regional or private insurance Exchange will need to develop supporting business processes that are efficient, innovative and best of

practice. The technology must support new business models; help review eligibility for government subsidies; handle different plan requirements; support employers, employees, individuals and brokers; process premiums; and track cost sharing. Our expertise can provide you with a solution that meets all of these challenges.

Our decades of experience in the Medicaid and CHIP eligibility determination and enrollment broker space as well as in the MMIS field give us an advantage in developing and managing Health Insurance Exchanges. As states begin choosing the outsourcing partners needed to meet the goals of successful insurance Exchanges, we believe they will be served best by relying on vendors with proven track records in a mix of public and private healthcare coverage programs along with the best of practice solutions. We offer several advantages that help you implement Exchanges smoothly and efficiently.

The development and management cycle of a Health Insurance Exchange can be long and complicated. To manage it efficiently, we break the process down into four distinct phases, finding efficiencies and helping you use best practices at every step.

Phase 1

- Establish the Exchange strategies, objectives and solutions
- Participate in the state-organized management team
- Create the best-of-practice database
- Identify potential insurance company and plan participants to create customized interfaces
- Conduct broker and agent focus groups to create models
- Develop financial modeling
- Design and development of educational Exchange web portal
- Evaluate need for internal or outsourced call center(s)
- Finalize implementation plan and outreach program, including the use of an educational portal

Phase 2

- Introduce implementation plan and staffing requirements
- Finalize financial model for Exchange sustainability

- Continual engagement with insurance companies, brokers and agents

- Detailed assessment of IT requirements and interfaces

- Analysis of integration capabilities and data with MMIS and HIE

- Test information dissemination processes for Exchange enrollment and application

- Test insurance plan interfaces of individual and small group employer plans

- Test on-line premium calculator

- Test premium calculation, billing, collection, aggregation and reconciliation

- Test integration with call center

- Upgrade capabilities of web portal

- Identify reporting requirements for state and federal government needs

- Participate in HHS sustainability evaluation
- Implement outreach program for Health Insurance Exchange

Phase 3

- Go live with state-specific insurance Exchange

- Monitor performance standards of web portal

- Evaluate health insurance company interfaces and information

- Monitor finance service capabilities and processes from insurance companies, brokers and agents as well as state and internal teams

- Test reporting requirements

- Monitor contact center capabilities and performance standards

- Test Medicaid/CHIP enrollment and eligibility capabilities and interfaces

Phase 4

- Introduce Medicaid/SCHIP enrollment and eligibility capabilities of web portal

- Monitor ongoing operations and improve processes of Health Insurance Exchange

- Add other insurance products and services

- Evaluate effectiveness and sustainability of financial model

- Monitor consumer experience

- Monitor compliance with state, federal and HHS legislation

Wherever you are in the process, we have the resources, innovative tools and expertise to help the State of Illinois plan for, develop and implement an Exchange that will help you meet requirements while providing excellent service to the Illinois stakeholders for the successful establishment of an Insurance Exchange in Illinois. Attached is a copy of "Health Insurance Exchanges: Connecting your people to coverage." We welcome and encourage you to contact us now or in the future as you venture into establishing and implementing an Insurance Exchange for Illinois.

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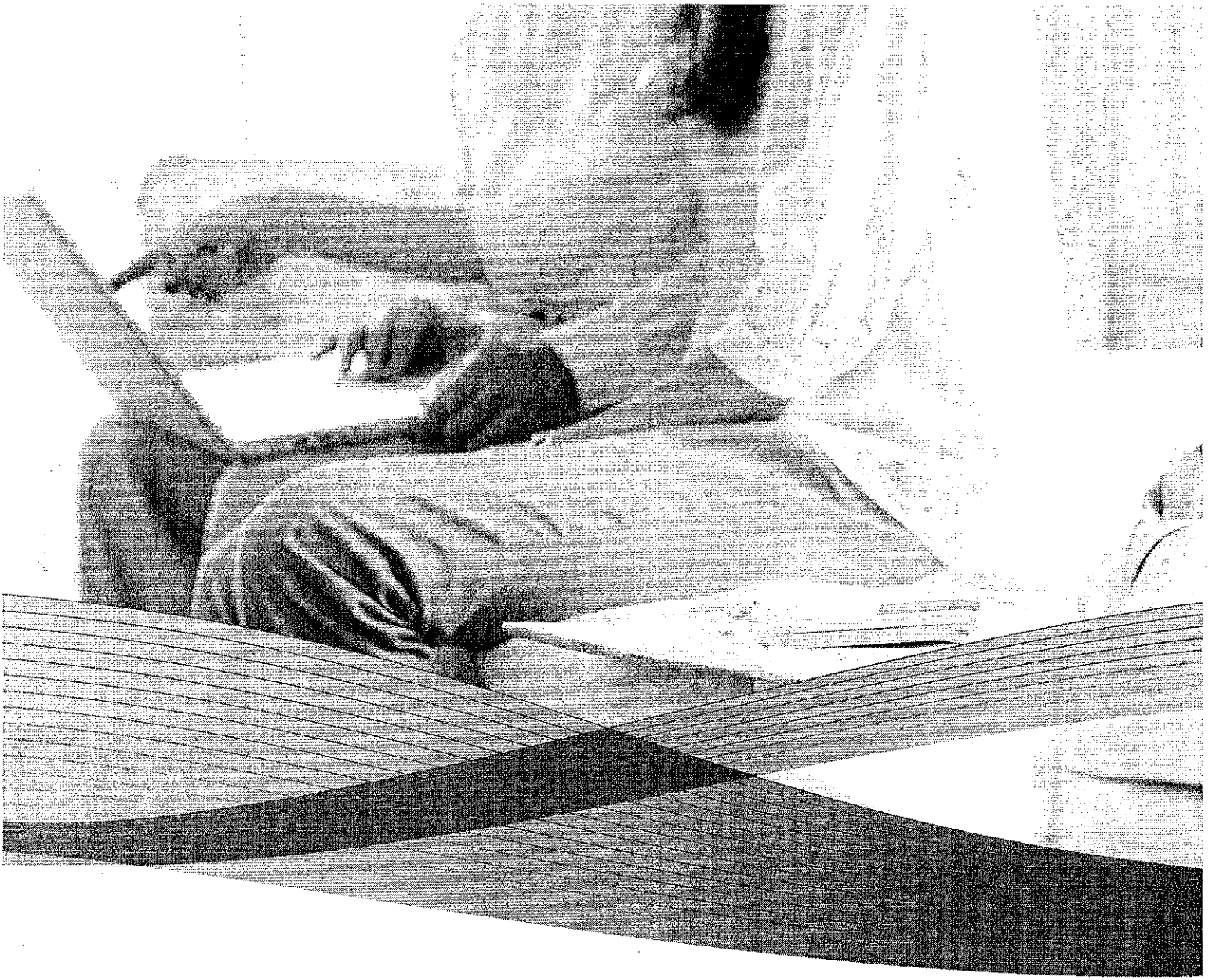


Health Insurance Exchanges

Connecting your people to coverage

ACS

A Xerox Company

Many people. Many options. Bring them together.

Recent legislation provides everyone in your state access to health insurance information—as well as a great challenge to your resources. In the next few years, every state must implement online portals for citizens to comparison shop for health insurance at competitive prices and choose a carrier. Successfully implementing and managing a Health Insurance Exchange requires a combination experience in healthcare, technology and administration.

You can get all three at once when you partner with ACS, A Xerox Company. Our solutions build on your population's health data to help match needs to the best-suited carriers while finding new financial services to pay for them. And our history of consulting, developing and maintaining health insurance exchanges means that we continually find new efficiencies through innovation. We connect your population to insurance—and your program to a stronger budget.

What is an Exchange?

Passed in March, 2010, the Patient Protection and Affordable Care Act (PPACA) contains several new healthcare reforms. Among them is a requirement for state-built and administered healthcare Exchanges to operate in each state by 2014. The Exchanges, which are expected to cover as many as 24 million people by 2019, will function as insurance markets and allow individuals and small businesses to purchase insurance from qualified health plans within the Exchange.

By law, HHS must establish minimum requirements for the Exchanges; but each state can determine the governing rules, powers and scope of the entities. States have the option of operating separate Exchanges for individuals and businesses or combining the Exchanges into a single entity that encompasses both groups. They also have several options regarding administration. A state may establish Exchanges for its different geographic areas, or it may join with other states to form a regional Exchange. States can also allow the federal government to operate their Exchanges.

Exchange development and management

The reform law stipulates that the Exchanges will be run by either the state government or by a state-recognized non-profit entity. The expectation is that almost all Exchanges will be administered by a state agency—either one now existing or one formed exclusively for the purpose of running the Exchange. Most states have already established public work groups to plan and design their Exchanges, and HHS has provided 48 states and the District of Columbia received $1 million each for this purpose.

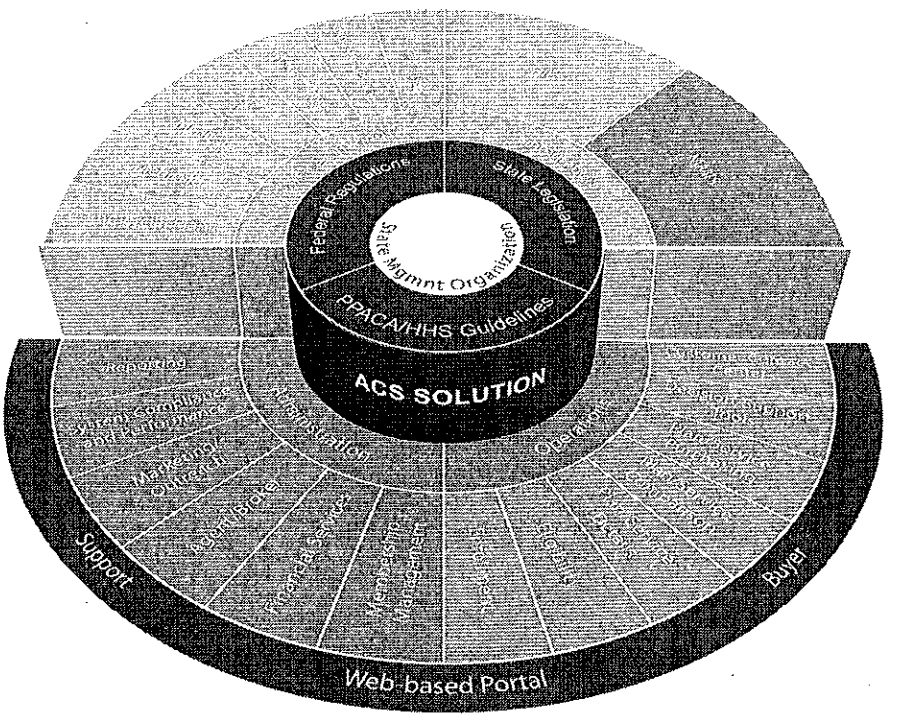
With so many entities working together, it's important to know everyone involved:

Insurance Commissioners

While they may not currently have adequate staff and resources to run an Exchange,

Health Insurance Exchange components

Integrated system of coverage



Insurance Commissioners will certainly play an integral role in shaping the management of their individual state's Exchange. As they are responsible for licensing companies to do business in the state, they will insist on evaluating and approving any insurance company seeking to participate in the Exchanges.

Medicaid and SCHIP agencies

These two agencies (often the same) have specific obligations to the Exchanges that are outlined in the enacted reform law, including:

- By 2015, states must report all changes in Medicaid enrollment to CMS. A substantial portion of that enrollment may come through Exchanges.
- Medicaid must enroll all people that the state Exchanges identify as eligible.
- Medicaid, SCHIP and the Exchange must use a secure electronic interface capable of determining individual's eligibility for coverage.
- When Medicaid/SCHIP finds people ineligible for those programs, provisions must be made to refer them to the Exchange to be reviewed for coverage and possible state-specific subsidy eligibility.

Because of these obligations, these agencies are heavily involved in how the Exchanges are forming in each state.

Newly created agencies

While new agencies could be created to run the Exchange, Medicaid programs and the insurance regulators are certain to be involved. These could be private nonprofit organizations, private for-profit contractors, or new state agencies such as the one created by Florida HealthChoices.

An effective Exchange partner

Our decades of experience in the Medicaid and MMIS fields give us an advantage in developing and managing Health Insurance Exchanges. As states begin choosing the outsourcing partners needed to meet the goals of successful insurance Exchanges, we believe they will be served best by relying on vendors with proven track records in a mix of public and private healthcare coverage programs along with the best of practice solutions. We offer several advantages that help you implement Exchanges smoothly and efficiently:

Consumer-focused approach

- Dedicated call centers responsive to unique needs of the populations we serve
- Deep experience with eligibility and enrollment services provides insight into effectively motivating individuals to action

Strong state relationships

- Existing relationships and in-depth knowledge of needs in 22 states
- 40 years of experience working with MMIS and eligibility solutions
- Information sharing to anticipate Exchange opportunities and needs

Understanding of commercial and government healthcare

- Leaders in integrated healthcare solutions, including MMIS, enrollment services, HIE, Exchanges, EHR and coordinated care management
- 40-year dedication to the government healthcare market better positions us for managing the challenges states face

Experienced Exchange team support

- Knowledge base includes enrollment, eligibility, IT and operations
- Participation in federal and state Exchange RFPs
- State-by-state analysis of Exchange and insurer activities

Best of practice partnerships

- Outstanding strategic partners who already have experience with Exchanges

Prepared for the future

- Evolution of Medicaid and CHIP
  - Reform and Exchanges will drive new markets and solutions
  - Incorporation into Exchanges beginning in 2015 or earlier
  - States are looking at Exchange requirements as enhancements
- Integration of MMIS, HIE, and Exchange systems
  - Creation of integrated total population management system
  - Innovative efficiency and data sharing solutions
  - Participate in risk-adverse management
- New partnerships and innovative offering to consumers
  - Expanding offerings: dental, long term care, services, Medicare Advantage
  - Introduction of quality and performance standards

- Access to data
  - Monitor and review population utilization, risk and expenditures

Our capabilities

Operating an Exchange involves handling massive amounts of information quickly, efficiently, and securely on behalf of millions of people. To be successful and sustainable, every state, regional or private insurance Exchange will need to develop supporting business processes that are efficient, innovative and best of practice. The technology must support new business models; help review eligibility for government subsidies; handle different plan requirements; support employers, employees, individuals and brokers; process premiums; and track cost sharing. Our expertise can provide you with a solution that meets all of these challenges.

Strategic planning and implementation

- Establishment of Exchange strategies, objectives, and solutions
- Management of Exchange implementation plan
- On-line educational Exchange portal
- Integration strategies for existing state systems

Basic exchange functionality administration

- Contact center/customer service/outreach
- Eligibility and enrollment services
- Financial services
- On-line portal-plan/service comparison, purchasing, and interfaces
- Decision support tools
- Employer outreach and public education

Guiding Exchange planning and development

The development and management cycle of a Health Insurance Exchange can be long and complicated. To manage it efficiently, we break the process down into four distinct phases, finding efficiencies and helping you use best practices at every step.

Phase 1

- Establish the Exchange strategies, objectives and solutions
- Participate in the state-organized management team
- Create the best-of-practice database and assess
- Identify potential insurance company and plan participants to create customized interfaces
- Conduct broker and agent focus groups to create models
- Develop financial modeling
- Introduction of educational Exchange web portal
- Evaluate need for internal or outsourced call center
- Finalize implementation plan and outreach program

Phase 2

- Introduce implementation plan and staffing requirements
- Finalize financial model for Exchange sustainability
- Continual meetings with insurance companies, brokers and agents
- Detailed assessment of IT requirements and interfaces
- Analysis of integration capabilities and data with MMIS and HIE
- Test information dissemination processes for Exchange enrollment and application
- Test insurance plan interfaces of individual and small group employer plans
- Test on-line premium calculator
- Test premium calculation, billing, collection, aggregation and reconciliation
- Test integration with call center
- Upgrade capabilities of web portal
- Identify reporting requirements for state and others
- Participate in HHS sustainability evaluation
- Implement outreach program for Health Insurance Exchange

Phase 3

- Go live with state-specific insurance Exchange
- Monitor performance standards of web portal
- Evaluate health insurance company interfaces and information
- Monitor finance service capabilities and processes from insurance companies, brokers and agents as well as state and internal teams
- Test reporting requirements for the state and others
- Monitor contact center capabilities and performance standards
- Test Medicaid/SCHIP enrollment and eligibility capabilities and interfaces

Phase 4

- Introduce Medicaid/SCHIP enrollment and eligibility capabilities of web portal
- Monitor ongoing operations and improve processes of Health Insurance Exchange
- Add other insurance products and services
- Evaluate effectiveness and sustainability of financial model
- Monitor consumer experience
- Monitor compliance with state, federal and HHS legislation

Wherever you are in the process, we have the resources, innovative tools and expertise to help your program plan for, develop and implement an Exchange that will help you meet requirements while providing excellent service to your constituents.

Contact us

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About ACS

ACS is part of Xerox's $22 billion global enterprise with 140,000 employees serving our clients in 160 countries.

You can learn more about us at www.acs-inc.com.

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